(2) For purposes of this section, a responsible physician or hospital ''knowingly'' violates section 1867 of the Act if the responsible physician or hospital recklessly disregards, or deliberately ignores a material fact.

(d)(1) In any case in which it is determined that more than one person was responsible for presenting or causing to be presented a claim as described in paragraph (a) of this section, each such person may be held liable for the penalty prescribed by this part, and an assessment may be imposed against any one such person or jointly and severally against two or more such persons, but the aggregate amount of the assessments collected may not exceed the amount that could be assessed if only one person was responsible.

(2) In any case in which it is determined that more than one person was responsible for presenting or causing to be presented a request for payment or for giving false or misleading information as described in paragraph (b) of this section, each such person may be held liable for the penalty prescribed by this part.

(3) In any case in which it is determined that more than one person was responsible for failing to report information that is required to be reported on a medical malpractice payment, or for improperly disclosing, using, or permitting access to information, as described in paragraphs (b)(5) and (b)(6) of this section, each such person may be held liable for the penalty prescribed by this part.

(4) In any case in which it is determined that more than one responsible physician violated the provisions of section 1867 of the Act or of § 489.24 of this title, a penalty may be imposed against each responsible physician.

(5) Under this section, a principal is liable for penalties and assessments for the actions of his or her agent acting within the scope of the agency.

(e) For purposes of this section, the term ''knowingly'' is defined consistent with the definition set forth in the Civil False Claims Act (31 U.S.C. 3729(b)), that is, a person, with respect to information, has actual knowledge of information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information, and that no proof of specific intent to defraud is required.

[57 FR 3345, Jan. 29, 1992; 57 FR 9670, Mar. 20, 1992, as amended at 59 FR 32124, June 22, 1994; 59 FR 36086, July 15, 1994; 60 FR 16584, Mar. 31, 1995; 60 FR 58241, Nov. 27, 1995; 64 FR 39428, July 22, 1999; 65 FR 18550, Apr. 7, 2000; 65 FR 24415, Apr. 26, 2000; 65 FR 35584, June 5, 2000; 67 FR 76905, Dec. 13, 2002; 69 FR 28845, May 19, 2004]

§ 1003.103 Amount of penalty.

(a) Except as provided in paragraphs (b) through (k) of this section, the OIG may impose a penalty of not more than—

(1) $2,000 for each wrongful act occurring before January 1, 1997 that is subject to a determination under § 1003.102; and

(2) $10,000 for each wrongful act occurring on or after January 1, 1997 that is subject to a determination under § 1003.102.

(b) The OIG may impose a penalty of not more than $15,000 for each person with respect to whom a determination was made that false or misleading information was given under § 1003.102(b)(4), or for each item and service that is subject to a determination under § 1003.102(a)(5) or § 1003.102(b)(9) of this part. The OIG may impose a penalty of not more than $100,000 for each arrangement or scheme that is subject to a determination under § 1003.102(b)(10) of this part.

(c) The OIG may impose a penalty of not more than $11,000[1] for each payment for which there was a failure to report required information in accordance with § 1003.102(b)(5), or for each improper disclosure, use or access to information that is subject to a determination under § 1003.102(b)(6).

(d)(1) The OIG may impose a penalty of not more than $5,000 for each violation resulting from the misuse of Departmental, CMS, Medicare or Medicaid program words, letters, symbols or emblems as described in § 1003.102(b)(7) relating to printed media, and a penalty of not more than

[1] As adjusted in accordance with the Federal Civil Monetary Penalty Inflation Adjustment Act of 1990 (Pub. L. 101–140), as amended by the Debt Collection Improvement Act of 1996 (Pub. L. 104–134).

$25,000 in the case of such misuse related to a broadcast or telecast, that is related to a determination under § 1003.102(b)(7).

(2) For purposes of this paragraph, a violation is defined as—

(i) In the case of a direct mailing solicitation or advertisement, each separate piece of mail which contains one or more words, letters, symbols or emblems related to a determination under § 1003.102(b)(7);

(ii) In the case of a printed solicitation or advertisement, each reproduction, reprinting or distribution of such item related to a determination under § 1003.102(b)(7); and

(iii) In the case of a broadcast or telecast, each airing of a single commercial or solicitation related to a determination under § 1003.102(b)(7).

(e) For violations of section 1867 of the Act or § 489.24 of this title, the OIG may impose—

(1) Against each participating hospital with an emergency department, a penalty of not more than $50,000 for each negligent violation occurring on or after May 1, 1991, except that if the participating hospital has fewer than 100 State-licensed, Medicare-certified beds on the date the penalty is imposed, the penalty will not exceed $25,000; and

(2) Against each responsible physician, a penalty of not more than $50,000 for each negligent violation occurring on or after May 1, 1991.

(f)(1) The OIG may, in addition to or in lieu of other remedies available under law, impose a penalty of up to $25,000 for each determination by CMS that a contracting organization has—

(i) Failed substantially to provide an enrollee with required medically necessary items and services and the failure adversely affects (or has the likelihood of adversely affecting) the enrollee;

(ii) Imposed premiums on enrollees in excess of amounts permitted under section 1876 or title XIX of the Act;

(iii) Acted to expel or to refuse to reenroll a Medicare beneficiary in violation of the provisions of section 1876 of the Act and for reasons other than the beneficiary's health status or requirements for health care services;

(iv) Misrepresented or falsified information furnished to an individual or any other entity under section 1876 or section 1903(m) of the Act;

(v) Failed to comply with the requirements of section 1876(g)(6)(A) of the Act, regarding prompt payment of claims; or

(vi) Failed to comply with the requirements of § 417.479 (d) through (i) of this title for Medicare, and § 417.479 (d) through (g) and (i) of this title for Medicaid, regarding certain prohibited incentive payments to physicians.

(2) The OIG may, in addition to or in lieu of other remedies available under law, impose a penalty of up to $25,000 for each determination by CMS that a contracting organization with a contract under section 1876 of the Act—

(i) Employs or contracts with individuals or entities excluded, under section 1128 or section 1128A of the Act, from participation in Medicare for the provision of health care, utilization review, medical social work, or administrative services; or

(ii) Employs or contracts with any entity for the provision of services (directly or indirectly) through an excluded individual or entity.

(3) The OIG may, in addition to or in lieu of other remedies available under law, impose a penalty of up to $100,000 for each determination that a contracting organization has—

(i) Misrepresented or falsified information to the Secretary under section 1876 of the Act or to the State under section 1903(m) of the Act; or

(ii) Acted to expel or to refuse to reenroll a Medicaid beneficiary because of the individual's health status or requirements for health care services, or engaged in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by section 1876 or section 1903(m) of the Act) with the contracting organization by Medicare beneficiaries and Medicaid beneficiaries whose medical condition or history indicates a need for substantial future medical services.

(4) If enrolles are charged more than the allowable premium, the OIG will impose an additional penalty equal to double the amount of excess premium

charged by the contracting organization. The excess premium amount will be deducted from the penalty and returned to the enrollee.

(5) The OIG will impose an additional $15,000 penalty for each individual not enrolled when CMS determines that a contracting organization has committed a violation described in paragraph (f)(3)(ii) of this section.

(6) For purposes of paragraph (f) of this section, a violation is each incident where a person has committed an act listed in §417.500(a) or §434.67(a) of this title, or failed to comply with a requirement set forth in §434.80(c) of this title.

(g) The OIG may impose a penalty of not more than $25,000 against a health plan for failing to report information on an adverse action required to be reported to the Healthcare Integrity and Protection Data Bank in accordance with section 1128E of the Act and §1003.102(b)(5)(ii).

(h) For each violation of §1003.102(b)(11), the OIG may impose—

(1) A penalty of not more than $50,000, and

(2) An assessment of up to three times the total amount of remuneration offered, paid, solicited or received, as specified in §1003.104(b).

(i) For violations of §1003.102(b)(14) of this part, the OIG may impose a penalty of not more than the greater of—

(1) $5,000, or

(2) Three times the amount of Medicare payments for home health services that are made with regard to the false certification of eligibility by a physician in accordance with sections 1814(a)(2)(C) or 1835(a)(2)(A) of the Act.

(j) The OIG may impose a penalty of not more than $10,000 per day for each day that the prohibited relationship described in §1001.102(b)(12) of this part occurs.

(k) For violations of section 1862(a)(14) of the Act and §1003.102(b)(15), the OIG may impose a penalty of not more than $2,000 for each bill or request for payment for items and services furnished to a hospital patient.

(l) For violations of section 351A(b) or (c) of the Public Health Service Act and 42 CFR part 73, the OIG may impose a penalty of not more than $250,000 in the case of an individual, and not more than $500,000 in the case of any other person.

(m) For violations of section 1860D–31 of the Act and 42 CFR part 403, subpart H, regarding the misleading or defrauding of program beneficiaries, or the misuse of transitional assistance funds, the OIG may impose a penalty of not more than $10,000 for each individual violation.

[57 FR 3346, Jan. 29, 1992, as amended at 59 FR 32125, June 22, 1994; 59 FR 48566, Sept. 22, 1994; 60 FR 16584, Mar. 31, 1995; 60 FR 58241, Nov. 27, 1995; 61 FR 13449, Mar. 27, 1996; 61 FR 52301, Oct. 7, 1996; 64 FR 39429, July 22, 1999; 65 FR 18550, Apr. 7, 2000; 65 FR 24416, Apr. 26, 2000; 65 FR 35584, June 5, 2000; 67 FR 76905, Dec. 13, 2002; 69 FR 28845, May 19, 2004]

§1003.104 Amount of assessment.

(a) The OIG may impose an assessment, where authorized, in accordance with §1003.102, of not more than—

(1) Two times the amount for each item or service wrongfully claimed prior to January 1, 1997; and

(2) Three times the amount for each item or service wrongfully claimed on or after January 1, 1997.

(b) The assessment is in lieu of damages sustained by the Department or a State agency because of that claim.

[65 FR 24416, Apr. 26, 2000]

§1003.105 Exclusion from participation in Medicare, Medicaid and all Federal health care programs.

(a)(1) Except as set forth in paragraph (b) of this section, the following persons may be subject, in lieu of or in addition to any penalty or assessment, to an exclusion from participation in Medicare for a period of time determined under §1003.107. There will be exclusions from Federal health care programs for the same period as the Medicare exclusion for any person who—

(i) Is subject to a penalty or assessment under §1003.102(a), (b)(1), (b)(4), (b)(12), (b)(13) or (b)(15); or

(ii) Commits a gross and flagrant, or repeated, violation of section 1867 of the Act or §489.24 of this title on or after May 1, 1991. For purposes of this section, a gross and flagrant violation is one that presents an imminent danger to the health, safety or well-being of the individual who seeks emergency